College of Pharmacists of British Columbia

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE AS A NON-PRACTISING AND/OR FORMER PHARMACIST

Application Form

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal Name _____

Last name (Surname) *First name* *Middle name*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____

City *Province*

_____ Reg # _____

Postal code *Country*

REQUIRED FEES

☐ Reinstatement fee

☐ Criminal record check fee

Pursuant to s. 54(2) of the *Health Professions Act Bylaws*, a registrant **must** notify the registrar immediately of any change of name, address, telephone number, electronic mail address, names and address of the pharmacies where the registrant provides pharmacy services, or any other registration information previously provided to the registrar.

Registrants can update their contact information using the eServices section of our website.

_____ _____

Date Applicant Signature

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the *Pharmacy Operations and Drug Scheduling Act*, *Health Professions Act*, and *Freedom of Information and Protection of Privacy Act*. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

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Notarized Identification

APPLICANT INFORMATION

Applicant full legal name _____
Last name (Surname) *First name* *Middle name*

Photo

Required Documents

- Passport photograph, taken within one year, affixed to space provided.
- Identification
  - Present one primary and one secondary (as in table below) to the Notary for certification
  - Submit a copy of the primary identification (both sides) with this form
- Present a name change or marriage certificate if name on any document is different from legal name.

Identification presented to the Notary must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document Type	Document Number	Document Type	Document Number
☐ Birth certificate		☐ Passport	
☐ Canadian citizenship card/certificate		☐ Valid Canadian driver's licence	
☐ Notarized affidavit (if applicable)*		☐ British Columbia identification card	
☐ Confirmation of Permanent Residence		☐ Naturalization certificate	
		☐ Canadian Forces identification	

*If you cannot provide a birth certificate or Canadian citizenship card/certificate you must provide a notarized affidavit that states your full legal name at birth, date of birth, place of birth and the reason why you cannot provide a birth certificate.

_____ _____
Date Applicant Signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ _____
Date Notary Signature

SEAL

Notary name _____
Address _____
_____
Tel _____

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Certification of Pharmacy Related Employment

EMPLOYEE INFORMATION

Employee name _____

Place of Work _____

Work Address _____

_____

_____

Work Tel _____ Work Fax _____

Employee Position _____ Total hours worked _____

Start date _____ End date _____

EMPLOYER CERTIFICATION

I certify that the above employment information is correct.

Name _____

Position _____

Pharmacy Manager / Pharmacy Owner / Human Resources Manager

_____ _____

Date Employer signature

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Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ , declare that *(check the appropriate boxes)*:

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make my registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC:

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant Signature

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Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Middle name*

Mailing address _____
Street *City/Town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver's Licence # _____

Birthdate _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name, informal name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care and Assisted Living Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. Criminal Records Review Act

Consent information can be found at:

http://www.bcpharmacists.org/library/3_Registration_Licensure/5144-CRC_Consent_Release_Information_Acknowledgement.pdf

Contact the College office if you cannot access the consent information.

- I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.
- I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis at least once every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

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PAYMENT OPTION

Applicant Name _____

Last name (Surname) *First name* *Middle name*

☐ Bank Draft/Money order
(payable to College of Pharmacists of BC)

☐ VISA ☐ MasterCard

Card # _____ Exp ____ /____

Cardholder name _____

Cardholder signature _____

Application fee	428.00
Criminal Record Check fee	28.00
GST	21.40
Total	**$ 477.40**
	GST # R106953920

For office use ONLY

iMIS ID: Finance stamp:

Reg initials:

Date to Finance: